DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 1

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 27, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.70

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ $ 15,000
b. FFY 2003 $ $27,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1 A & B, Supp. 1, pp 11 through 15.2; Attachment 3.1 C, pp 13 through 18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same pages replace
New pages add

10. SUBJECT OF AMENDMENT:
Home Health Criterion; Physician Review Every 60 Days; Other Technical Changes

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary, Health & Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:
P W Finnerty

13. TYPED NAME:
Patrick W. Finnerty

14. TITLE:
Director

15. DATE SUBMITTED: 3/5/2002

16. RETURN TO:
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Attn. Reg. Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/14/02

18. DATE APPROVED: JUN 6 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
2/27/02

20. SIGNATURE OF REGIONAL OFFICIAL:
Claudette V. Campbell

21. TYPED NAME:
CLAUDETTE V. CAMPBELL

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & STATE OPERATIONS

23. REMARKS:

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D. Other practitioners' services; psychological services, psychotherapy. Limits and requirements for covered services are found under Psychiatric Services (see 12VAC30-50-140 D).

1. These limitations apply to psychotherapy sessions provided, within the scope of their license, by licensed clinical psychologists or licensed clinical social workers/ licensed professional counselors/licensed clinical nurse specialists-psychiatric who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven day period.

2. Psychological testing is covered when provided, within the scope of their license, by licensed clinical psychologists or licensed clinical social workers/ licensed professional counselors/licensed clinical nurse specialist-psychiatric who are either independently enrolled or under the direct supervision of a licensed clinical psychologist.

7. Home Health services.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of a practitioner of the healing arts. Home health services shall be provided in accordance with guidelines found in the Virginia Medicaid Home Health Manual.

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to 32 visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional services unless authorized by DMAS.

C. Home health aide services provided by a home health agency.

1. Home Health Aides must function under the supervision of a registered nurse.

2. Home Health Aides must meet the certification requirements specified in 42 CFR 484.36.

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3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

1. Service covered only as part of a physician's plan of care.
2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered annually without authorization. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

E. The following services are not covered under the home health services program:

1. Medical social services;
2. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;
3. Community food service delivery arrangements;
4. Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;
5. Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and
6. Services related to cosmetic surgery.

§7.5. Durable medical equipment (DME) and supplies suitable for use in the home.

A. General requirements and conditions.

1. All medically necessary medical supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

2. DME providers shall adhere to all applicable DMAS' policies, laws, and regulations for durable medical equipment and supplies. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for durable medical equipment or supplies which are regulated by such licensing agency or agencies.

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3. DME and supplies must be furnished pursuant to a Certificate of Medical Necessity (CMN) (DMAS-352).

4. A CMN shall contain a physician's diagnosis of a recipient's medical condition and an order for the durable medical equipment and supplies that are medically necessary to treat the diagnosed condition and the recipient functional limitation. The order for DME or supplies must be justified in the written documentation either on the CMN or attached thereto. The CMN shall be valid for a maximum period of six months for Medicaid recipients 21 years of age and younger. The maximum valid time period for Medicaid recipients older than 21 years of age is 12 months. The validity of the CMN shall terminate when the recipient's medical need for the prescribed DME or supplies end.

5. DME must be furnished exactly as ordered by the attending physician on the CMN. The CMN and any supporting verifiable documentation must be complete (signed and dated by the physician) and in the provider's possession within 60 days from the time the ordered DME and supplies are initially furnished by the DME provider. Each component of the DME must be specifically ordered on the CMN by the physician. For example, the order must specify IV pole, pump, and tubing. A general order for IV supplies shall not be acceptable.

6. The CMN shall not be changed, altered, or amended after the attending physician has signed it. If changes are necessary, as indicated by the recipient's condition, in the ordered DME or supplies, the DME provider must obtain a new CMN. New CMNs must be signed and dated by the attending physician within 30 days from the time the ordered supplies are furnished by the DME provider.

7. DMAS shall have the authority to determine a different (from those specified above) length of time a CMN may be valid based on medical documentation submitted on the CMN. The CMN may be completed by the DME provider or other health care professionals, but it must be signed and dated by the attending physician. Supporting documentation may be attached to the CMN but the attending physician's entire order must be on the CMN.

8. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' post payment audit review purposes. DME providers shall not create or reviews CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Attending physicians shall not complete, nor sign and date CMNs once the post payment audit review has begun.

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B. Preauthorization is required for incontinence supplies provided in quantities greater than two cases per month.

C. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

1. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners

2. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office

3. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales)

4. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface;) mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes.

5. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (Effective July 1, 1989)

6. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; and support stockings;

7. Orthotics, including braces, splints, and supports

8. Home or vehicle modifications

9. Items not suitable for or not used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.)

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10. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.)

D. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachment 3.1 A & B.

E. Coverage of home infusion therapy. Home infusion therapy shall be defined as the intravenous administration of fluids, drugs, chemical agents, or nutritional substances to recipients in the home setting. DMAS shall reimburse for these services, supplies, and drugs on a service day rate methodology established in Attachment 4.19 B (12 VAC 30-80-30). The therapies to be covered under this policy shall be: hydration therapy, chemotherapy, pain management therapy, drug therapy, and total parenteral nutrition (TPN). All the therapies which meet criteria will be covered for three months. If any therapy service is required for longer than the original three months, prior authorization shall be required for the DME component for its continuation. The established service day rate shall reimburse for all services delivered in a single day. There shall be no additional reimbursement for special or extraordinary services. In the event of incompatible drug administration, a separate HCPCS code shall be used to allow for rental of a second infusion pump and purchase of extra administration tubing. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Implementation Form. Proper documentation shall include the need for pump administration of the medications ordered, frequency of administration to support that they are ordered simultaneously, and indication of incompatibility. The service day rate payment methodology shall be mandatory for reimbursement of all I.V. therapy services except for the recipient who is enrolled in the Technology Assisted waiver program. The following limitations shall apply to this service:

1. This service must be medically necessary to treat a recipient's medical condition. The service must be ordered and provided in accordance with accepted medical practice. The service must not be desired solely for the convenience of the recipient or the recipient's caregiver.

2. In order for Medicaid to reimburse for this service, the recipient must:

   (a) Reside in either a private home or a domiciliary care facility, such as an adult care residence. Because the reimbursement for DME is already provided under institutional reimbursement, recipients in hospitals, nursing facilities, rehabilitation centers, and other institutional settings shall not be covered for this service.

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(b) Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy.

(c) Have body sites available for peripheral intravenous catheter or needle placement or have a central venous access; AND

(d) Be capable of either self-administering such therapy or have a caregiver who can be adequately trained, is capable of administering the therapy, and is willing to safely and efficiently administer and monitor the home infusion therapy. The caregiver must be willing to and be capable of following appropriate teaching and adequate monitoring. In those cases where the recipient is incapable of administering or monitoring the prescribed therapy and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

F. The medical equipment and supply vendor must provide the equipment and supplies as prescribed by the physician on the certificate of medical necessity. Orders shall not be changed unless the vendor obtains a new certificate of medical necessity prior to ordering or providing the equipment or supplies to the patient.

G. Medicaid shall not provide reimbursement to the medical equipment and supply vendor for services provided prior to the date prescribed by the physician or prior to the date of the delivery or when services are not provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the medical equipment and supply vendor may not bill the Medicaid recipient for the service that was provided.

H. The following criteria must be satisfied through the submission of adequate nd verifiable documentation satisfactory to the Department. Medically necessary DME and supplies shall be:

1. Ordered by the physician on the CMN;

2. A reasonable and necessary part of the recipient's treatment plan;

3. Consistent with the recipient's diagnosis and medical condition particularly the functional limitations and symptoms exhibited by the recipient;

4. Not furnished solely for the convenience, safety, or restraint of the recipient, the family, attending physician, or other practitioner or supplier;

5. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and

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6. Furnished at a safe, effective, and cost effective level suitable for use in the recipient's home environment.

I. Coverage of enteral nutrition (EN) which does not include a legend drug shall be limited to when the nutritional supplement is the sole source form of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of EN shall not include the provision of routine infant formulae. A nutritional assessment shall be required for all recipients receiving nutritional supplements.

8. Private duty nursing services.

A. Not provided.

9. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus were carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. are provided to outpatients;

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or more hours of service in a given day.

(6) Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

(7) Services shall be provided following a diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker or certified psychiatric nurse and in accordance with an ISP which must be fully completed within 30 days of initiation of the service.

I. Home Health Services

1. Home health services which meet the standards prescribed for participation under Title XVIII, excluding any homebound standard, will be supplied.

2. Home health services shall be provided by a licensed home health agency on a part-time or intermittent basis to a recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care which the physician shall review, sign, and date at least every 60 days.

3. Covered Services: Any one of the following services may be offered as the sole home health service and shall not be contingent upon the provision of another service.

a. Nursing services,

b. Home health aide services,

c. Physical therapy services,

d. Occupational therapy services, or

e. Speech-language pathology services.

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4. General Conditions. The following general conditions apply to skilled nursing, home health aide, physical therapy, occupational therapy, and speech-language pathology services provided by home health agencies.

   a. The patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

   b. Services shall be furnished under a written plan of care and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition. The initial plan of care must be reviewed, signed, and dated by the attending physician, or physician designee, no later than 21 days after the implementation of the plan of care.

   c. A physician re-certification shall be required at intervals of at least once every 60 days, must be signed and dated by the physician who reviews the plan of care, and should be obtained when the plan of care is reviewed. The physician re-certification statement must indicate the continuing need for services and should estimate how long home health services will be needed.

   d. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

   e. A written physician's statement located in the medical record must certify that:

      (1) The patient needs licensed nursing care, home health aide services, physical or occupational therapy, or speech-language pathology services,

      (2) A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

      (3) These services were furnished while the individual was under the care of a physician.

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f. The plan of care shall contain at least the following information:

(1) Diagnosis and prognosis,
(2) Functional limitations,
(3) Orders for nursing or other therapeutic services,
(4) Orders for home health aide services, when applicable,
(5) Orders for medications and treatments, when applicable,
(6) Orders for special dietary or nutritional needs, when applicable, and
(7) Orders for medical tests, when applicable, including laboratory tests and x-rays

5. Utilization review shall be performed by DMAS to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Such post payment review audits may be unannounced. Services not specifically documented in patients' medical records as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

6. All services furnished by a home health agency, whether provided directly by the agency or under arrangements with others, must be performed by appropriately qualified personnel. The following criteria shall apply to the provision of home health services:

a. Nursing Services. Nursing services must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Home Health Aide Services. Home health aides must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aide services may include assisting with personal hygiene, meal preparation and feeding, walking, and taking and recording blood pressure, pulse, and respiration. Home health aide services must be provided under the general supervision of a registered nurse. A recipient may not receive duplicative home health aide and personal care aide services.

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c. Rehabilitation Services. Services shall be specific and provide effective treatment for patients' conditions in accordance with accepted standards of medical practice. The amount, frequency, and duration of the services shall be reasonable. Rehabilitative services shall be provided with the expectation, based on the assessment made by physicians of patients' rehabilitation potential, that the condition of patients will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with the specific diagnosis.

(1) Physical therapy services shall be directly and specifically related to an active written plan of care designed and personally signed and dated by a physician after any needed consultation with a physical therapist licensed by the Board of Physical Therapy. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Physical Therapy or a physical therapy assistant who is licensed by the Board of Physical Therapy and is under the direct supervision of a physical therapist licensed by the Board of Physical Therapy. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This supervisory visit shall not be reimbursable.

(2) Occupational therapy services shall be directly and specifically related to an active written plan of care designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This supervisory visit shall not be reimbursable.

(3) Speech-language pathology services shall be directly and specifically related to an active written plan of care designed and personally signed and dated by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology.

d. A visit shall be defined as the duration of time that a nurse, home health aide, or rehabilitation therapist is with a client to provide services prescribed by a physician and that are covered home health services. Visits shall not be defined in measurements or increments of time.

J. Durable Medical Equipment (DME) and Supplies.

a. DME provider shall retain copies of the CMN and all applicable supporting documentation on file for post payment audit reviews. Durable medical equipment and supplies that are not ordered on the CMN for which reimbursement has been made by Medicaid will be retracted. Supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation does not replace the requirement for a properly completed CMN. The dates of the supporting documentation must coincide with the dates of service on the CMN and the medical practitioner providing the supporting documentation must be identified by name and title.

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DME providers shall not create or reviews CMNs or supporting documentation for durable medical equipment and supplies provided after the post payment audit review has been initiated.

b. Persons needing only DME/Supplies may obtain such services directly from the DME provider without having to consult or obtain services from a home health service or home health provider. DME/supplies must be ordered by the physician, be related to the medical treatment of the patient, and the complete order must be on the CMN for persons receiving DME/Supplies. Supplies used for treatment during the visit are included in the visit rate of the home health provider. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

K. Optometrists' services are limited to examinations (refractions) after preauthorization by the State Agency except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).